HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 1 1

2. STATE: West Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 438 et seq.
42 CFR 422.128 42; CFR 489.100, 42 CFR 431.51
42 CFR 447.60, 42 CFR 435 et seq.

7. FEDERAL BUDGET IMPACT:
a. FFY -0- $ -0-
b. FFY -0- $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 1.4 pg. 9
Section 2.1(c) pg 11
Section 3.1(a)(10) pg. 22
Section 4.29 pg. 77
Section 4, pgs. 41, 45(a); 45(b); 46; 50a; 71
Section 4.18 (vii) pgs. 54; 55
Section 4.30(b)(1)(B) pg [redacted] 78a
Att. 2.2-A pgs. 10; 10A
Table of Contents
ATT 4.30 pg 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
S Amt

10. SUBJECT OF AMENDMENT:
Preprint plan amendment to comply with Balanced Budget Act Medicaid Care regulations

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Nancy V Atkins

13. TYPED NAME:
Nancy V. Atkins, MSN, RNC, NP

14. TITLE:
Commissioner

15. DATE SUBMITTED:
September 23, 2003

16. RETURN TO:
Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
SEPTEMBER 25, 2003

18. DATE APPROVED: DEC 17 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JULY 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
MARY T. McSORLEY

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR, DMCH

23. REMARKS:

LIST OF ATTACHMENTS

No.	Title of Attachments
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

State: West Virginia

Citation		Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	(a)	The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below: The State will monitor for violations based on findings from on-site surveys, enrollee or other complaints, financial status or any other source including failure to comply with local, state and federal regulations and provider agreements obligations. Sanctions include suspension of new enrollments; possible retention of a portion of capitation payments, nonrenewal of the contract or termination of the MCO contract.
	(b)	The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management: The definition of threshold the State applies to an MCO for repeated violations, subject to temporary management, is when the MCO has repeatedly failed to meet the substantive requirements of Sections 1903(m) or 1932 of the Social Security Act and continued operation of the MCO would be hazardous to the enrollees. If the State imposes the additional sanction of temporary management as set forth in 42 CFR 438.706(b), the Commissioner of the Department of Insurance shall be responsible for the imposition of such a sanction as set forth in Section 33-25A-19 of the West Virginia HMO Act of 1977.
	©	The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e). ____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs

State: West Virginia

Citation	1.4	State Medical Care Advisory Committee
42 CFR 431.12(b) AT-78-90		There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and meeting all the requirements of 42 CFR 431.12.
42 CFR 438.104		X The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

_____ The State elects not to guarantee eligibility.

____ The State elects to guarantee eligibility. The minimum enrollment period is month (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

State: West Virginia

Agency*	Citation(s)	Groups Covered
1932(a)(4) of the Act	B.	Optional Groups Other Than Medically Needy (continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56.

This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

_____ Disenrollment rights are restricted for a period of ____ months (not to exceed 12 months).

During the first three month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

__X__ No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

__X__ The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

_____ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and		(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

Citation 3.1(a)(9)

Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /_/

The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240(a)(10) and 440.250

Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932 of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

(iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

/_/

** Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

State: West Virginia

Citation		4.10 Free Choice of Providers
42 CFR 431.51 AT 78-90 46 FR 48524 48 FR 23212 1902(a)(23) P.L. 100-93 (section 8(f)) P.L. 100-203	(a)	Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their (section availability on a prepayment basis.
(Section 4113)	(b)	Paragraph (a) does not apply to services furnished to an individual –
		(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
		(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or
		(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act.
Section 1902(a)(23) Of the Social Security Act P.L. 105-33		(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or
Section 1932(a)(1) Section 1905(t)		(5) Under an exception allowed under 42 CFR 438.50, or 42 CFR 440.168, subject to the limitations in paragraph (c).
	(C)	Enrollment of an individual eligible for medical assistance in aprimary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

Citation

1902 (a)(58)
1902(w) 4.13(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether